Communication and the Medical Interview

Strategies for Learning and Teaching

Craig B. Kaplan, MD, MA, Benjamin Siegel, MD, Janet M. Madill, MD, MEd, Ronald M. Epstein, MD

The broad goal of this article is to direct clinician-educators to ways to improve their knowledge about medical interviewing and their communication skills, as well as to note ideas and resources for teaching in this area. Our specific objectives are to outline the knowledge base, specific skills, and attitudes and values relevant to effective communication in the context of the clinical interview, and to suggest strategies and resources that can be used by clinician-educators to learn and teach them. The article is not intended to be a critical review of the literature on communication and interviewing, nor is it an in-depth discussion of the knowledge base and skills to be learned. For these we refer the reader to specific references, texts, and other resources. This article will provide a summary road atlas to the broad field of communication and medical interviewing; cited literature and suggested learning resources will provide local detail maps for readers who are interested in more in-depth treatments of specific areas.

Why should clinician-educators be interested in communication and interviewing? Effective communication in clinical settings increases the likelihood that (1) the information gathered from patients to make diagnostic assessments is accurate and reliable; (2) patients recognize that the physician is genuinely interested in them and their care; (3) physicians and patients reach common ground on diagnosis and treatment; and (4) patients are motivated to play an active role in their own care.[1,2] In this way, the interview determines the accuracy of the diagnostic assessment as well as the quality of the doctor-patient relationship, thereby affecting the entire diagnostic-therapeutic process. In short, better communication leads to better diagnosis and treatment.

Better communication leads to better outcomes. Research has documented that communication during the interview is positively related to specific illness outcomes,[3,4] as well as to satisfaction among patients[5,7] and physicians.[8] On the other hand, poor communication has been related to such adverse events as malpractice suits[9,10] and patient decisions to leave practices or health care organizations.[11]

In the clinical setting, most physicians and their patients benefit from high-quality, effective communication skills. Clinician educators will find it especially valuable to improve their communication skills, as strong skills will also bring important benefits in the educational and academic settings in which they work. In the educational setting, effective teaching and learning depend greatly on the exchange of information and quality of the relationship between students and teachers.[12,13] Skills that promote effective communication in the clinical setting are also effective in the educational setting.

Clinician-educators are in a unique position to use this overlap of skills. It is often possible to model specific communication skills for students during teaching sessions, then explicitly point out their parallel use with patients. This can result in powerful experiential learning. Students who directly experience effective communication (e.g., through the teacher's expressions of empathy or partnership, or encouragement of active participation and autonomy) may be more likely to use those skills with their patients.

The benefits of effective communication also extend to academic life. As clinician-educators interact with peers and superiors in the academic environment, they benefit from their own communication skills such as attentive listening, empathy, negotiation, and limit setting. Again, what is learned in one setting can be appropriately applied to others. Continuing mentoring and reflection will facilitate this transfer of skills among clinical, educational, and academic settings.

Some have argued that being an effective communicator is part of the "art" of medicine, implying that the ability to communicate is a natural talent with which one is or is not born.[14] We disagree. Communication skills are specific and observable, and can be evaluated objectively. There is ample evidence that continuing education programs designed for physicians in practice improve skills,[15–18] and research with medical students has shown that the benefits from training persist years after the course has been completed.[19] Knowledge and skills associated with effective communication and interviewing can be improved through practice, using the strategies and resources we outline in this article.

SUGGESTED KNOWLEDGE BASE AND SKILLS

The tables in this article have been extensively adapted from Lipkin, Quill, and Napodano's seminal article defining

Received from the Primary Care Program in Medicine, Department of Internal Medicine, Strong Memorial Hospital, University of Rochester (CBK) and Highland Hospital Primary Care Institute, Program for Biopsychosocial Studies, Departments of Family Medicine and Psychiatry (RME), University of Rochester, Rochester, NY; Department of Pediatrics, Boston (Mass.) University (BS); and Primary Care Clinic, Good Samaritan Hospital and Medical Center, Portland, Ore. (JMM).

Address correspondence and reprint requests to Dr. Kaplan: University of Rochester, Department of Internal Medicine, 601 Elmwood Avenue, Box 702, Rochester, NY 14642-8702.

Table 1. Suggested Knowledge Base*

1. Understand the stages of an interview and their management
- **a. Opening**
- **b. Agenda setting**
- **c. Characterization of present concerns and life setting**
- **d. Negotiating a diagnosis and treatment plan**
- **e. Patient education and motivating behavior change**
- **f. Closing and follow-up**

2. Understand functions of the interview
- **a. Developing a working relationship**
- **b. Communicating interest and commitment to patient**
- **c. Calibrating and overcoming barriers to communication**
- **d. Surveying patient concerns and gathering relevant information**
- **e. Prioritizing concerns and establishing limits**
- **f. Arriving at common ground about diagnosis and treatment**
- **g. Enhancing the patient education and motivation**

3. Define several forms of questions
- **a. Open-ended**
- **b. Closed-ended**
- **c. Directive**
  - **i. Biased (leads or biases the patient's response)**
  - **ii. Unbiased (does not lead patient; neutral)**

4. Understand nonverbal behavior (patient's, physician's) and what may be communicated nonverbally

5. Understand several models of the doctor-patient and doctor-patient-family relationship and explore their clinical applications
- **a. Mechanistic (physician active; patient passive)**
- **b. Paternalistic (physician provides guidance; patient cooperates)**
- **c. Collaborative (physician and patient participate mutually)**

6. Understand dimensions and manifestations of illness from a systems perspective (microcellular → organ → person → family → culture)
- **a. Understand family systems perspective**
- **b. Understand developmental perspective**

7. Understand the components of a mental status examination and how to use it
8. Define the characteristics of a helping relationship
9. Understand elements of clinical reasoning
   - a. Discuss differences between biopsychosocial and biomedical models of patient care and treatment
   - b. Understand cognitive process involved in diagnostic reasoning (including hypothetico-deductive method)
10. Develop awareness of patients' needs for autonomy in decision-making processes
11. Define types of patients who require specialized knowledge and different interviewing and treatment styles
    - a. Patients with cognitive impairment or neurologic disorders
    - b. Patients with difficult personality styles
    - c. Patients with common mental health disorders
      - i. Depression
      - ii. Anxiety
      - iii. Somatization
      - iv. Substance abuse
12. Understand different or specialized interviewing styles called for by certain situations
    - a. Eliciting a sexual history
    - b. Bereaved patients and families
    - c. Delivering "bad" news
    - d. Discussing end-of-life issues with patients and families
    - e. Providing anticipatory guidance to patients and families
      - i. Injury prevention
      - ii. Violence prevention
      - iii. Sexual behavior
    - f. Mediating stress and conflict within families or with other caregivers
    - g. Helping patients and families cope with the effects of illness
      - i. Exacerbations of chronic illness
      - ii. Acute, life-threatening illness

Table 1. Continued

13. Define transference and countertransference and explore how each affects medical relationships
14. Explore strategies for truthful disclosure and informed consent
15. Understand personal and developmental aspects of being a clinician
    a. Awareness of magnitude and impact of stress on physicians and their families
    b. Recognition of one's personal strengths and weaknesses when dealing with patients
    c. Awareness of one's personal response to stress
    d. Awareness of one's personal responses to different clinical situations and types of patients
    e. Awareness of how one's background affects responses to different clinical situations and types of patients

**Adapted with permission from Lipkin, Quill, and Napodano.[20] Core areas of knowledge (see text) are identified in boldface.*

a core curriculum for internal medicine residency training programs.[20] The tables have been reorganized and expanded to include key concepts from the disciplines of family medicine and pediatrics. They can been used as a curriculum guide for clinician-educators who want to improve their own clinical interviewing and communication skills. The tables can also be used to guide and provide structure for teaching activities in this domain.

Tables 1 and 2 outline the knowledge base and specific skills to be learned. We have taken a comprehensive approach to these tables—although not exhaustive, they contain a large knowledge base and a great number of skills. Clinician-educators, who often have relatively little protected time to devote to educational activities, may find the lists somewhat daunting. However, one need not become a "master" to benefit from improved communication skills. We believe that working on and improving even relatively small subsets of knowledge and skills can have lasting positive effects on clinical and teaching activities. The tables are offered as a menu of educational activities that, when undertaken over time, will improve conduct of and teaching about the medical interview. One need not sample the entire menu to enjoy the meal!

We suggest focusing initially on the knowledge and skills in boldface at the beginning of each table (identified as "core"), unless one particular area of knowledge or set of skills looks particularly inviting. These core knowledge areas and skill sets are important because they apply to every interview one is likely to perform or teach about. For example, a conceptual understanding of the stages and functions of the interview will not only facilitate the clinical interview per se, but also will help clinician-educators to model interviews and provide feedback to learners. A common understanding of the process and functions of the interview allows teachers and learners to organize their observations and greatly facilitates subsequent discussion. Similarly, understanding the several types of questions used in clinical interviews and being able to observe nonverbal behavior are core concepts that contribute greatly to the effectiveness of almost every interview and provide structure for ensuing discussion with learners when present.

With regard to skills (Table 2), expressing interest in and commitment to the patient, eliciting the story of illness, and using verbal and nonverbal means to facilitate communication are all essential to successful interviewing and teaching. In addition, interviewers must avoid behavior that hinders communication and learn to recognize common communication barriers.

Beyond the essential or core knowledge and skills, there is no "right" way to proceed, nor is any one area of knowledge or set of skills an absolute prerequisite for another. When addressing individual learning needs, clinician-educators may choose to focus on areas that seem relevant or interesting based on their personal experience. When teaching, another helpful way to focus is to invite learners to identify their most important perceived needs in learning about interviewing. For example, residents who see a high percentage of patients with somatization may be motivated to learn more about surveying patient problems, negotiating and selecting priorities, and limit setting.

In Table 3, we have identified knowledge and skills that pertain to teaching clinical interviewing. The broader topic of clinical teaching has been addressed elsewhere in this supplement. However, in Table 3 we draw particular attention to a subset of teaching skills that, in our experience, are especially relevant to teaching communication and interviewing.

ATTITUDES AND VALUES

The principles and practices of patient-centered (or relationship-centered) interviewing are essential to effective work in this area. This interviewing style has been described as one that "actively involves the patient and ensures that his or her perceptions, needs, and concerns are articulated during the physician-patient interaction."[21] Certain attitudes and values are crucial to effectively using the patient-centered knowledge and skills we have outlined. These attitudes and values are outlined in Table 4. Attention to them encourages a greater participatory or "power-sharing" relationship with the patient and family. Although we acknowledge the difficulties inherent in teaching them, it is important to be explicit about attitudes and values that underlie the knowledge and skills we address with learners. Also, there is evidence in medical education settings that teacher behavior that is con-

Table 2. Specific Skills to Be Learned*

1. Competently elicit the patient's story of illness that includes
- **a. Detailed delineation of symptoms**
- **b. Exploration of broader life setting in which symptoms occur**
- **c. Consideration of influence of family, social, and psychological factors and patient's illness**
- **d. Sensitive exploration of mental status**

2. Express interest in and commitment to the patient
- **a. Verbal behaviors: introduce self, get patient's name clear, attend to physical comfort, elicit patient's view of the problem, elicit patient's request, clarify extent of commitment, discuss questions, offer support and partnership, state and demonstrate respect**
- **b. Nonverbal behaviors: touch, maintain comfort, eye contact**

3. Facilitate communication
- **a. Verbal behaviors: allow patient to give his or her own story of illness, use a balance of open-ended and closed-ended techniques, use nonbiasing questions, seek clarification of vague or ambiguous data, summarize periodically, use empathy when appropriate, echo patient's words and affect, adopt a nonjudgmental attitude, express unconditional positive regard**
- **b. Nonverbal behaviors: arrange space comfortably, nod, show affect, use posture that communicates interest, echo patient's nonverbal behavior, pay quiet attention**

4. Avoid behavior that hinders communication
- **a. Verbal behavior to be avoided: use of technical language, injecting biases, false or premature reassurance, avoidance of difficult topics, discussion of fees first, discounting or dismissing concerns ("there is nothing wrong — it's all in your head"), frequent interruptions**
- **b. Nonverbal behaviors to be avoided: using posture that communicates disinterest, reading or writing note during the interview, allowing interruption, having closed posture, breaking eye contact**

5. Calibrate and overcome barriers to communication (deafness, language or cultural differences, high anxiety, strong affect)
- **a. Check barriers and compensate (e.g., talk louder, get interpreter)**
- **b. Observe verbal and nonverbal signs of barriers at outset**
- **c. Inquire in an open-ended way about affect**
- **d. Be open to a "hidden agenda"**
- **e. Recognition and characterization of mental status changes when present**

6. Negotiation and contacting — share responsibility for patient care
- **a. Survey patient's problems**
- **b. Prioritize problems and set limits**
- **c. Elicit patient's view of illness and patient's request**
- **d. Be willing to individualize treatment plans**
- **e. Check patient's understanding of diagnosis and treatment plan**

7. Demonstrate use of family assessment and interviewing skills
   - a. Identifying family members relevant to presenting problem
   - b. Arranging family meetings
   - c. Establishing a therapeutic alliance with each family member
   - d. Eliciting each family member's perspective on the problem
   - e. Identifying family strengths and adaptive mechanisms
   - f. Understanding and adapting to family dynamics
     - i. Identifying family roles and hierarchy
     - ii. Identifying conflict, triangulation, alliances, and collusion
   - g. Negotiating a mutually agreeable treatment plan
     - i. Soliciting the family's help in the treatment plan
     - ii. Facilitating communication among family members
     - iii. Refraining from taking sides
8. Encourage patient's use of self-help skills
   - a. Seek and integrate patient's experience with illness into treatment plan
   - b. Encourage patient to take control of own care as appropriate
   - c. Use specific therapies (behavior modification, crisis intervention) when appropriate
   - d. Define the patient's strengths and use them in the treatment process

**Adapted with permission from Lipkin, Quill, and Napodano.[20] Core skill areas (see text) are identified in boldface.*

Table 3. Skills Relevant to Teaching Communication and Interviewing

1. Giving feedback to learners based on direct observation, audiotapes, or videotapes
2. Using role modeling
3. Using role play and simulated patients
4. Exploring affective issues and promoting personal awareness in learners

sistent with humanistic values fosters their development in learners.[22]

STRATEGIES FOR IMPROVING COMMUNICATION

We have listed in the Appendix some easily available references that can be read at one's leisure. Reading alone, however, will not suffice for skills development. Improving skills requires opportunities to observe and be observed, to practice, and to receive constructive feedback. Following are some strategies for improving skills.

Individual Work

A number of things can be done individually to improve skills. Aside from reading, there are often opportunities to see skills modeled at local lectures and workshops. These are frequently given by individuals other than physicians (social workers, nurses, clinical psychologists), so it may take some effort to locate them. There are also commercially available audiotapes and videotapes that provide excellent examples of skilled interviewers. Several sources for such tapes are included in the Appendix.

Reading, attending lectures, and viewing tapes provide the opportunity to conceptualize skills and see them demonstrated, but do not allow for practice or feedback. Obtaining such feedback is obviously difficult when working alone; however, it is possible to audiotape or videotape oneself during clinical or teaching sessions. Later review of these tapes can be fruitful, even without another person to review them. Finally, consider asking patients or family members for feedback about how well an interview has gone for them. Explore what did and did not work. Although some patients may not want to offend and will have no comments, others may give helpful feedback. Another benefit to asking for such feedback may be a considerably enhanced relationship with them. One of us (BS) taught a course for first-year medical students in which students reviewed their videotapes of hospitalized patients in a seminar. The patients who were videotaped were invited to participate in the feedback and reflective process.

Table 4. Attitudes and Values to Be Fostered in Oneself and Others*

1. Unconditional positive regard for patients, families, and caregivers (if not necessarily their actions)
2. Respect for patient autonomy and individuality
3. Willingness to share some of the diagnostic and treatment process with patients, families, and caregivers
4. Willingness to work with and learn from patients with diverse backgrounds and personal styles
5. Curiosity about and attention to the different dimensions (biological, psychological, social, and spiritual) of illness that may occur simultaneously
6. Openness, curiosity, and willingness to explore one's own attitudes, beliefs, and expectations as they relate to being a physician

**Adapted with permission from Lipkin, Quill, and Napodano.*[20]

Work with Others

Although it may not always be possible, we encourage working with others to improve skills. It can be difficult to view a tape of oneself and see everything that there is to learn. We all have selective attention and blind spots, especially when we are the focus of our own scrutiny! The best learning often occurs when someone else points out a particular habit we didn't realize we had, or makes an observation that we missed.

The simplest strategy is to find someone willing to review audiotapes or videotapes of patient interviews and provide constructive feedback. Finding others with similar interests will allow everyone to benefit from one another's feedback. If no one is available locally, seek out courses or workshops that provide the opportunity to obtain feedback from others. Such events are regularly offered nationally and regionally. The Appendix lists several organizations that offer courses and workshops.

Group work can also enable one to focus on the affective domain: feelings and personal reactions we have as clinicians and teachers. These strong feelings are common, and can be barriers to improving skills if they remain unaddressed. Addressed appropriately, they can provide the basis for valuable learning experiences. Periods of reflection alone and in groups will deepen experiential learning. This has important implications for the clinician-educator in both learning and teaching roles. A number of different styles of groups have been developed to facilitate physician exploration of feelings.[23] Balint groups are common in family medicine training programs.[24] Other groups that encourage and facilitate discussion of feelings include personal awareness and family-of-origin groups. Such groups may be available locally, or it may be possible to organize one. Psychologists, social workers, psychiatrists, and other mental health professionals often have training in facilitating such groups and may be willing to help in the effort.

Another means of maintaining interest and learning is to join one or more national organizations that have teaching medical interviewing as a principal focus. Several such organizations are listed in the Appendix.

EDUCATIONAL RESOURCES

Written Materials

There is a rich research literature in this area, although relying on published articles is complicated by the large number of journals in different disciplines that publish relevant studies. We recommend beginning with one or more excellent, recent textbooks. A good text will include a reference list for more detailed reading to follow-up particular interests if desired. The Appendix lists several texts and articles. Many of them are directed toward teaching interviewing skills. To help organize reading, we recommend developing a list of specific goals. Such goals might vary from "understanding a conceptual model of the medical interview" to "improving my ability to handle patients with multiple symptoms." It is best to derive goals from one's own interest and clinical experience.

Videotapes and Audiotapes

Many videotapes and audiotapes are available that outline and demonstrate basic concepts and skills. Their quality varies greatly. Sample local and regional medical libraries first. The Appendix lists some sources for audiotapes and videotapes.

Seeking out opportunities for active skill practice and feedback is the next step. This applies equally for interviewing per se and teaching about interviewing. Many clinician-educators will want to spend at least some of their time practicing teaching skills in the context of interviewing.

Brief Workshops

Brief workshops from 2 to 8 hours provide conceptual overviews, as well as the chance to practice specific skills and obtain feedback. They will also facilitate meeting others with similar interests. Brief communications workshops are often available at annual meetings of specialty and subspecialty organizations, including the Society of General Internal Medicine, Society for Behavioral Pediatrics, Society of Teachers of Family Medicine, American Academy of Family Physicians, Ambulatory Pediatrics Association, American Academy of Pediatrics, and the American College of Physicians. "Stand-alone" workshops and courses are regularly offered by several organizations, many of which also provide help for organizing and hosting local events. These organizations and their telephone numbers are listed in the Appendix.

Longer Courses and Extended Training

More intensive training is also available. The Society of Teachers of Family Medicine offers an annual conference focused on the family and associated communications skills. The American Academy on Physician and Patient (AAPP) offers communications courses lasting from 1 to 5 days. The AAPP also has a Facilitator Training Program which "trains trainers"—that is, faculty who wish to be certified to train other faculty in medical interviewing. Several academic institutions, including New York University and the University of Rochester, offer fellowships and minifellowships that emphasize communication.

Intuition and the limited data available suggest that longer educational experiences are of greater value than shorter ones.[16] However, not everyone can afford the time or money it takes to attend long courses or fellowship programs. We stress that even brief experiences can have significant value. One strategy is to engage in multiple, relatively brief experiences over time. This may be an especially good strategy if a specific plan is followed for selecting experiences and time between workshops is used to practice skills and gain experience.

FINANCING EDUCATIONAL ACTIVITIES

Protecting the time and finding financial support to pursue interests may seem difficult, particularly as financial pressure on academic centers and clinical departments makes such resources scarce. Aside from paying out-of pocket, there are strategies for finding money to attend meetings, workshops, and longer experiences. Remember that the value of communication skills is increasingly acknowledged by medical school deans, department chairs, and leaders within managed care organizations (several large HMOs have recently undertaken educational ventures to improve their members' communication skills). When specifically asked, these individuals may be willing to fund or partially fund educational activities, especially if the request is part of an overall plan that will clearly benefit the organization.

Rarely, local foundations or corporations may sponsor educational activities if they see them as relevant to their missions. It is especially helpful to frame requests in terms of specific institutional, organizational, or community needs that will be addressed by the event. Emphasize the specific activities that will occur as a consequence of the event and how these activities will meet the needs and interests of the foundation or company. Such activities may include coordinating or teaching a communications course, conducting communications workshops for faculty or housestaff, or participating in continuing educational activities for clinical faculty and community physicians.

CONCLUSIONS

Interviewing and communication—with patients, students, and colleagues—is a vital part of the clinician-educator's mission. Research shows that better communication improves clinical outcomes. Clinician-educators will find that better communication also greatly facilitates their educational and academic activities. Many educational experiences are available to the clinician-educator who pursues a thoughtful strategy to improve personal knowledge and skills, as well as teaching, in this area.

REFERENCES

1. Cohen-Cole SA. The Medical Interview: The Three-Function Approach. St. Louis, Mo: Mosby-Year Book; 1991.
2. Lipkin ML, Putnam S, Lazare A, eds. The Medical Interview: Clinical Care, Education, and Research. New York, NY: Springer-Verlag; 1994.
3. Henbest RJ, Stewart M. Patient-centredness in the consultation, 2: does it really make a difference? Fam Prac. 1990;90:28–33.
4. Kaplan SH, Greenfield S, Ware J. Impact of the doctor-patient relationship on the outcomes of chronic disease. In: Stewart M, Roter D, eds. Communicating with Medical Patients. Newbury Park, Calif: Sage Publications; 1989;228–45.
5. Ware, JE Jr, Snyder MK. Dimensions of patient attitudes regarding doctors and medical care services. Med Care. 1975;13:669–82.
6. Buller MK, Buller DB. Physicians' communication style and patient satisfaction. J Health Soc Behav. 1987;28:375–88.
7. Feletti G, Firman D, Sanson-Fisher R. Patient satisfaction with primary-care consultations. J Behav Med. 1986;9:389–99.
8. Suchman AL, Roter D, Green M, Lipkin M Jr. Physician satisfaction with primary care office visits. Collaborative Study Group of the American Academy on Physician and Patient. Med Care. 1993; 31:1083–92.
9. Beckman H. Communication and malpractice: why patients sue their physicians. Clev Clin J Med. 1995;62:84.
10. Levinson W. Physician-patient communication. A key to malpractice prevention. JAMA. 1994;272:619–30.
11. Kasteler J, Kane RL, Olsen DM, Thetford C. Issues underlying prevalence of "doctor-shopping" behavior. J Health Soc Behav. 1976; 17:329–39.
12. Mattern WD, Weinholtz D, Friedman CP. The attending physician as teacher. N Eng J Med. 1983;308:1129–32.
13. Dagget CJ, Cassie JM, Collins GF. Research on clinical teaching. Rev Educ Res. 1979;49:151–69.
14. Engel GL. What if music students were taught to play their instruments as medical students are taught to interview? The Pharos. (Fall) 1982:12–13.
15. Roter DL, Hall JA, Kern DE, Barker LR, Cole KA, Roca RP. Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. Arch Intern Med. 1995; 95:1877–84.
16. Levinson W, Roter D. The effects of two continuing medical education programs on communication skills of practicing primary care physicians. J Gen Intern Med. 1993;8:318–24.
17. Bensing JM, Sluijs EM. Evaluation of an interview training course for general practitioners. Soc Sci Med. 1985;20:737–44.
18. Gask L, McGrath G, Goldberg D, Millar T. Improving the psychiatric skills of established general practitioners: evaluation of group teaching. Med Educ. 1987;21:362–8.
19. Maguire P, Fairbairn S, Fletcher C. Consultation skills of young doctors, I: benefits of feedback training in interviewing as students persist. Br Med J Clin Res Ed. 1986;292:1573–6.
20. Lipkin M Jr, Quill TE, Napodano RJ. The medical interview: a core curriculum for residencies in internal medicine. Ann Intern Med. 1984;100:277–84.
21. Smith RC, Hoppe RB. The patient's story: integrating the patient- and physician-centered approaches to interviewing [see comments]. Ann Intern Med. 1991;115:470–7.
22. Williams GC, Deci EL. Internalization of biopsychosocial values by medical students: a test of self-determination theory. J Pers Soc Psychol. 1996;70:767–79. Abstract.
23. Epstein RM, Campbell TL, Cohen-Cole SA, McWhinney IR, Smilkstein G. Perspectives on patient-doctor communication [see comments]. J Fam Pract. 1993;37:377–88.
24. Scheingold L. Balint work in England: lessons for American family medicine. J Fam Pract. 1988;26:315–20. Abstract.

APPENDIX

Additional Resources

A) Texts and review articles (in addition to literature cited)

Gordon GH, Baker L, Levinson W. Physician-patient communication in managed care. West J Med. 1995;163:527–31.

Korsch BM. Pediatric interviewing techniques. Curr Probl Pediatr. 1973;3:1–42.

Korsch BM. What do patients and parents want to know? What do they need to know? Pediatrics. 1984;74:917–9.

Smith RC, Hoppe RB. The patient's story: integrating the patient- and physician-centered approaches to interviewing. Ann Intern Med. 1991;115:470–7.

Epstein R. Perspectives on patient-doctor communication. J Fam Pract. 1993;37(4):377–88.

B) Sources for audiotapes and videotapes

American Academy on Physician and Patient, McLean, Va; (703) 556-9222.

Bayer Institute for Health Care Communication, West Haven, Conn; (800) 800-5907.

COMSORT, Baltimore, Md; (410) 467-1100.

Boston (Mass) Area Health Education Center; (617) 534-5258 [for further information contact Eric Hardt, MD, (617) 638-6176, eric.hardt@bmc.org].

Medical Interview Tapes; (919) 966-3378 [contact Eric Jensen, MD].

Symposia Foundation/Kaiser-Permanente; (619) 632-8882.

C) Organizations that emphasize communication and interviewing

American Academy on Physician and Patient, McLean, Va; (703) 556-9222.

Bayer Institute for Health Care Communication, West Haven, Conn; (800) 800-5907.

Common Ground Solutions, Lee's Summit, Mo; (816) 478-1711.

Group on Doctor-Patient Communication of the Society of Teachers of Family Medicine; (800) 274-2247.

Northwest Center for Physician-Patient Communication, Lake Oswego, Ore; (503) 636-2234.

University of Rochester (NY) Program for Biopsychosocial Studies; (716) 263-6355.